(1) Supreme Court, U.S.
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Supreme Court of the United States

LYNNE FEIGENBAUM, PETITIONER

v.

MERRILL LYNCH & CO., INC. BASIC LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR; MERRILL LYNCH & CO., INC. SUPPLEMENTAL LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR; METROPOLITAN LIFE INSURANCE CO.; PLAN ADMINISTRATORS of the MERRILL LYNCH RETIREMENT PLAN, HEALTH INSURANCE PLAN, AND LIFE INSURANCE PLAN; MERRILL LYNCH & CO., INC; CORPORATIONS 1-30, fictitious defendants; Amended per Clerk's Order dated 10/1/07

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The United States Court of Appeals for the Third Circuit affirmed the district court's decision to uphold the Respondents' benefit determination to terminate Petitioner's long-term disability benefits. Petitioner was a participant in an "employee welfare benefit plan" established pursuant to the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1001, et. seq. ("ERISA"). The claim challenges the propriety of the affirmance because it was premised upon the *post hoc* supposition and argument of counsel raised in litigation to bolster the claim determination and ascribe an additional reason for the benefit termination other than the one set forth in the denial letters contained in the administrative record. The Court's acceptance of the argument is unsupported by any facts, documentation or reports contained in the record. The Third Circuit's affirmance further deprived Petitioner of a "full and fair" review of the benefit determination under the "combination-of-factors method of review" enunciated by this Court in *Metropolitan Life Insurance Company v. Glenn*, 128 S. Ct. 2343 (2008). The Third Circuit's opinion also failed to address Petitioner's arguments that the district court erroneously denied numerous discovery requests intended to demonstrate the fiduciary's bias in the administration of the claim and the conflict of interest it operated under.

Based upon an argument outside the administrative record, the Third Circuit upheld as lawful a benefit termination where: (a) the fiduciary expressly agreed to obtain medical records necessary to confirm Petitioner's continued entitlement to benefits under the ERISA Plan; (b) obtained medical records that were subjected to four (4) separate medical reviews, which

supported the continued payment of long-term benefits for thirty-one (31) months; (c) the termination of benefits was premised upon the identical 139 pages of medical records reviewed by the fiduciary to approve benefits; and (d) the fiduciary intentionally withheld from Petitioner information on objective testing recommended by its own medical consultant that would have - - and ultimately did - - confirm her continued disability.

Three questions are presented:

1. Did the Circuit Court err by not applying the "combination-of-factors method of review" to the benefit determination at issue because it erroneously accepted a *post hoc* argument regarding Petitioner's medical treatment that was both outside of and unsupported by the administrative record?

2. Did the Circuit Court erroneously fail to remand the matter to the district court to review the benefit determination under the "combination-of-factors method of review" when the district court's original opinion pre-dated the *Glenn* decision and it also accepted a *post-hoc* argument concerning Petitioner's medical treatment that was both outside of and unsupported by the administrative record.

3. Was the Petitioner denied a full and fair review of the lawfulness of the benefit determination based upon the district court's rulings on discovery sought to confirm the extent of bias, conflict of interest, and procedural irregularities associated with the benefit determination, which were ignored by the Third Circuit in its opinions.

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The opinion of the United States Court of Appeals affirmed the August 2, 2007 decision of the United States District Court for the District of New Jersey. Both opinions are unpublished (1a, 5a), but are reported at 2009 U.S. App. LEXIS 2005 (3d Cir. February 2, 2009) and 2007 U.S. Dist. LEXIS 56360 (D.N.J. August 2, 2007).

JURISDICTION

The Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

The Third Circuit's opinion was rendered on February 2, 2009. Despite undisputed confirmation that the opinion was premised upon an argument and reasoning extraneous to the benefit determination and administrative record, the Petition for Panel Rehearing with Suggestion for Rehearing EN BANC was denied on March 3, 2009. (24a) The Court provided an extension of time to file the petition based upon the application of counsel of record.

RELEVANT PROVISIONS INVOLVED

Title 28 United States Code, Section 1132(a)(1)(B).

> A civil action may be brought by a participant . . . to recover benefits due him under the terms of this plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan.

Title 28 United States Code, Section 1133.

> In accordance with regulations of the Secretary, every employee benefit plan shall –
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reason for such denial, written in a manner calculated to be understood by the participant, and
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Title 29 Code of Federal Regulation, Section 2560.503-1(b)

> * * *
>
> (3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing in adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g.,

in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, **within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section**, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant, and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

* * *

29 Code of Federal Regulation, Section 2560.503-1(g)(1)

Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification

of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant - -

(i) The specific reason and reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by the group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was

relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

29 Code of Federal Regulation, Section 2560.503-1(h)(3)

* * *

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

* * *

STATEMENT

Petitioner, Lynne Feigenbaum ("Feigenbaum") seeks the continued payment of long-term disability benefits under an "employee welfare plan" as defined by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, et. seq. ("ERISA") ("Plan" or "the Plan"). The Plan is sponsored Merrill Lynch & Co. ("Merrill Lynch") to provide disability benefits to eligible employees. Merrill Lynch provides self-funded basic disability benefits while MetLife insures supplemental disability benefits. (A300)[1] MetLife administers both Basic and Supplemental disability benefits pursuant to an Administrative Services Agreement entered with Merrill Lynch. (A460)

Feigenbaum has been and remains totally disabled as a result of vestibular compression and other medical conditions that result in dizziness, vertigo, loss of balance, extreme sensitivity to light and sound, joint pain and fatigue. (A612-617) These symptoms forced Feigenbaum to stop working on July 26, 2000. (Id.) Feigenbaum's disabling symptomology has never been refuted. MetLife paid total disability benefits for almost three (3) years based upon these symptoms. The medical records contained in the administrative record confirm that Feigenbaum underwent two (2) separate head surgeries to improve her disabling symptomology. The medical documentation in the

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[1] Citations to the Appendix that accompany this Petition are designated "1a" through "25a". Citations in the Statement of Case that begin with "A" refer to the Appendix submitted to the Third Circuit.

administrative record also indicates that Feigenbaum pursued and attended all treatment modalities prescribed by her attending physicians.

MetLife approved Feigenbaum's claim for disability benefits by correspondence dated June 15, 2001. (A653) MetLife represented to Feigenbaum that **"while you are receiving long-term disability benefits we will be requesting updated medical information from your physicians, on an annual basis."** (A654) (Emphasis added) During the three (3) years it paid benefits, MetLife obtained medical documentation it chose to obtain when it wanted. MetLife accumulated 139 pages of medical reports, office notes, physical/vestibular therapy records, operative reports and laboratory reports concerning Feigenbaum's medical conditions. MetLife reviewed these records on four (4) separate occasions and approved the continued payment of long-term disability benefits.

At no time during the three (3) year interim did MetLife advise Feigenbaum of any difficulty obtaining medical records. MetLife never requested updated medical records from Feigenbaum. MetLife never advised Feigenbaum that her benefits were in jeopardy of termination because she, or any of her physicians, had failed to provide information requested by MetLife. MetLife did not request updated medical records from all treatment providers identified in the administrative record, as it promised to do, contemporaneous with its decision to terminate disability benefits.

Finally, MetLife never questioned the frequency, appropriateness or nature of the medical

treatment prescribed for Feigenbaum's disabling medical condition. The administrative record does not contain any medical analysis of this issue and MetLife's benefit determination did not rest, any way, upon the nature of Feigenbaum's medical treatment. During the period benefits were paid, MetLife never sought information from Feigenbaum concerning her continued medical treatment or therapy or why it had been prescribed.

The 139 pages of medical records MetLife obtained during its payment of disability benefits did not indicate an improvement in Feigenbaum's medical condition or an amelioration of her symptoms. MetLife conducted four (4) internal reviews of the medical records it obtained on June 15, 2001 (A501-502), October 15, 2001 (A502-503), January 31, 2002 (A503), November 18, 2002 (A504) and November 3, 2003 (A504-505). Because it determined to "continue" the payment of long-term disability benefits, MetLife necessarily concluded that Feigenbaum had met the terms and conditions of the Plan, including its proof of loss provision.

One month after the November 3, 2003 review, MetLife requested that Dr. Amy Hopkins review the same 139 pages of medical documentation it had previously obtained, reviewed and determined were sufficient to establish Feigenbaum's continued disability. MetLife did not request any additional medical information from Feigenbaum or her attending physicians prior to Dr. Hopkins' review. MetLife did not ask Dr. Hopkins to opine on the appropriateness of Feigenbaum's medical treatment or whether there was

alternative treatment available to improve her disabling medical condition or symptomology.

Rather, MetLife simply asked whether the medical documents **"support an impaired function that would preclude ...[Feigenbaum] from performing her sedentary job."** (A578) (Emphasis added) Dr. Hopkins never answered this question. In her review, Dr. Hopkins simply summarized, in a biased manner, the medical documentation and cherry-picked information from the medical records to reach her conclusion that "no physical impairment was objectively documented which would preclude [Feigenbaum] from [return to work] [full-time], own occupation, no restrictions or limitations." (A571)

MetLife never requested "objective" evidence that supported Feigenbaum's disability before Dr. Hopkins' "independent physician consult" ("IPC'). Nor did it request this information during the period between Dr. Hopkins' medical record review and the date disability benefits were initially terminated.

Instead, it sent Dr. Hopkins' medical record review to Feigenbaum's primary care physician, Dr. Frank Alario. (A567) MetLife advised Dr. Alario in its transmittal letter that it would assume he agreed with Dr. Hopkins' conclusions if he did not respond in ten (10) days. The administrative record does not confirm that Dr. Alario was aware of Dr. Hopkins' report or his need to respond to her conclusions. The administrative record is clear, however, that MetLife intentionally concealed its request to Dr. Alario from Feigenbaum. MetLife's unit manager directed that its letter to Dr. Alario, as well as Dr. Hopkins' report, not be sent to

Feigenbaum. (A505) MetLife further concealed postugraphy testing referenced by Dr. Hopkins in her report. Dr. Hopkins did not criticize Feigenbaum's treatment, but was surprised that no postugraphy test had been performed. (A570) Dr. Hopkins asserted that this test would objectively confirm Feigenbaum's disability. (Id.)[2] MetLife never advised Ms. Feigenbaum of this test or its importance prior to terminating her disability benefits.

Despite the fact that MetLife never requested "objective" evidence to support Feigenbaum's disability during the three (3) years benefits were paid, it terminated her benefits based upon a purported lack of such evidence. MetLife made this decision based entirely upon Dr. Hopkins' conclusion even though it did not answer the specific question asked of Dr. Hopkins in the IPC referral form.

Feigenbaum appealed MetLife's initial termination *pro se*. As part of the appeal she submitted an updated report from Dr. Alario. (A835) In his report, Dr. Alario confirmed Feigenbaum's continued disability and thus clearly disagreed with the conclusions of Dr. Hopkins. He further advised that Feigenbaum would be undergoing additional testing. (Id.) Instead of providing guidance on the test recommended by Dr. Hopkins, MetLife simply denied Feigenbaum's appeal based upon her failure to meet an

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[2] Feigenbaum underwent postugraphy testing on October 29, 2004, which confirmed her continued disability. (A891). This test was consistent with a previous postugraphy test done in 1996, which was interpreted as abnormal. (A507)

objective standard introduced into the adjudicative matrix by Dr. Hopkins, not MetLife.

The Court rested its opinion to affirm the district court's decision on an issue foreign to the administrative record - - Feigenbaum's medical treatment at the time MetLife terminated her disability benefits. Simply put, the Third Circuit's searching analysis of Feigenbaum's individual claim under the standard adopted by this Court in *Glenn* amounted to equating the frequency and nature of Feigenbaum's medical treatment temporal to the benefit determination with the existence of her continued disability. This conclusion has no basis in the administrative record. MetLife did not initially terminate disability benefits based on Feigenbaum's continued treatment for her disabling medical condition or symptoms. Nor could MetLife terminate benefits on this basis because there is no medical analysis contained in the administrative record to base such a conclusion.[3] In its initial denial letter, MetLife simply stated, in pertinent part:

> This decision is based on a review of the documentation contained on your file, which includes but is not limited to reports from your doctors. We also had your entire file reviewed by an independent physician consultant.

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[3] The Third Circuit's comment concerning the dearth of treatment records temporal to MetLife's benefit determination is prima facia evidence of MetLife's breach of fiduciary duty. MetLife did not, as it promised Feigenbaum, obtain updated treatment records from all of her medical providers to evaluate her continued disability.

* * *

> No documentation was submitted to indicate any impairments that would prevent you from performing your occupation.

The initial denial letter referenced medical documentation submitted in support of Feigenbaum's disability claim, but did not assert that Feigenbaum did not submit requisite documents. MetLife selectively obtained the medical documentation it deemed relevant based upon its previous representation to Feigenbaum. MetLife's determination was not based on any failure by Feigenbaum to comply with the proof of loss provision of the Plan. Nor could Feigenbaum meet this burden based upon MetLife's intentional decision to keep her in the dark with respect to the proofs necessary to maintain her disability benefits.

The Third Circuit stated in its opinion that Feigenbaum did not submit any documents in support of her administrative appeal. This is also wrong. Feigenbaum submitted the report of her long-term attending physician, which flatly contradicted the conclusions of Dr. Hopkins. (A835) MetLife did not consider Dr. Alario's report to provide "objective" proof of disability. (A843-844) At the time, however, MetLife had hid from Feigenbaum the one test that would have objectively established her disability.

In its appeal denial, MetLife advised Feigenbaum that it was upholding its initial claim determination, in part because: "In summary, the documentation does not support an inability to perform the duties of your sedentary job as of January 22, 2004

onward. Accordingly, the withdrawal was found to be appropriate." (A843-844) The "documentation" referred to was the 139 pages of medical records MetLife obtained. No where in this letter, or any other document contained in the administrative record, does MetLife premise its decision on Feigenbaum's failure to provide medical documentation in accordance with the Plan's proof of loss provision.

In erroneously concluding that Feigenbaum failed to provide documentation she did not know she had to produce to support this claim, the Third Circuit avoided answering the quintessential question raised: How can identical medical records establish the existence of a disability for three (3) years and also provide a basis to suddenly terminate benefits. This is simply not possible.

MetLife did not argue the merits of its claim determination before the district court or the Third Circuit. Rather, it adopted a *post-hoc* lawyer argument that the decrease in treatment records contained in the administrative record supported MetLife's claim denial. MetLife equated the existence and extent of Feigenbaum's disability to the number of medical records it promised to obtain during the administrative review process. However, MetLife never terminated Feigenbaum's claim on this basis. This argument is unsupported by a single fact or document contained in the administrative record. MetLife never obtained a medical opinion that supported the conclusion that the type and frequency of Feigenbaum's treatment contradicted Feigenbaum's continued disability. Absent this opinion, arguments concerning the lack of medical treatment are not part of the administrative

record and cannot be used to bolster MetLife's benefit determination.

REASONS FOR GRANTING THE PETITION

Feigenbaum was and remains totally disabled. She cannot work on a daily basis, Feigenbaum endures a myriad of disabling symptoms resulting from a medical condition for which she underwent two separate surgeries to her head. She has followed her attending physicians' treatment and therapy recommendations to the letter in order to improve her disabling symptomology. These facts are undisputed by a single medical record, physician report or office note contained in the administrative record. Despite the existence of any documentation to the contrary, both the district court and Third Circuit sanctioned a clearly erroneous and unsupported benefit determination.

This anomaly did not result from the mechanical application of a burden-shifting, sliding scale, procedural or evidentiary rule-of-law applicable to ERISA cases, which this Court found "undesirable." *Glenn*, 128 S. Ct. at 2351. Instead, it was the product of an administrative review process that was neither "full" nor "fair", as well as the Third Circuit's unexplained willingness to overlook MetLife's egregious breach of its fiduciary obligations by focusing on an argument and facts outside of the administrative record. This is evidenced by the Third Circuits terse opinion, which specifically stated:

> Suffice it to say that the evidence that Feigenbaum's reported vertigo has a physiologic

> basis supporting the presence of a significant balance disorder preventing full-time work was sparse.

3(a) This observation is completely irrelevant to the issue of whether MetLife's benefit determination in this case was lawful because: (1) MetLife never questioned the "physiologic basis" that supported Feigenbaum's balance disorder; (2) MetLife did not base its benefit determination on the absence of "physiologic" proof supporting her disability; and (3) MetLife did not base its benefit determination on the purported sparsity of medical or other evidence supporting Feigenbaum's continued disability.

The Third Circuit's observation is outside the administrative record and only supported by MetLife's counsel's arguments made, for the first time, during the litigation of this matter to bolster its claim determination. By accepting and relying upon arguments not contained in the administrative record or denial letters sent to Feigenbaum, the district court and Third Circuit ignored a rule of law deeply imbedded in ERISA jurisprudence - - the record to be reviewed in litigation is limited to the administrative record before the plan administrator. *Abnathya v. Hoffman LaRoche*, 2F.3d 40, 48 n.8 (3d Cir. 1993); *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 300 (5th Cir. 1998). The Third Circuit inexplicably broke from this precedent in the wake of the *Glenn* decision. However, this Court in *Glenn* did not alter this well established rule-of-law. Id., at 2350. ("Trust law continues to apply a deferential standard of review to the discretionary decisionmaking of a conflicted trustee. . . .") To the contrary, this Court specifically held that

it would not "overturn Firestone by adopting a rule that in practice could bring about near universal review by judges de novo - - i.e., without deference - - of the lion's share of ERISA plan claim denials." Id.

The Third Circuit's opinion represents a substantial departure from the manner in which all circuit courts, including itself, adjudicate ERISA claims. The substantive consideration of arguments outside the administrative record is simply not permitted and directly conflicts with the holding of every circuit court that has addressed this issue. In the parlance of *Glenn*, the Third Circuit rested its decision on a non-evidentiary "factor" since it was never considered or relied upon by MetLife when it rendered its benefit determination. In addition to creating a conflict with other circuit courts, as well as within its own circuit, the Third Circuit's opinion so far departed from the accepted and usual ERISA course as to mandate the exercise of this Court's supervisory power. This Court is a disabled woman's last resort and reliance upon its supervisory powers and is all that stands between the erroneous affirmance of an equally erroneous benefit determination, that could not withstand, even the most deferential review of ERISA cases.

Feigenbaum's entitlement to disability benefits under an ERISA-governed plan, like any similar benefit claim, can hardly be characterized as a "great" legal case. In light of this Court's watershed opinion in *Glenn*, however, the following admonition comes to mind:

> Great cases like hard cases made bad law. For great cases are called great, not by reason of their real importance in shaping the law of the future, but because of some accident of immediate overwhelming interest which appeals to the feeling of distorts the judgment. These immediate interests exercise a kind of hydraulic pressure which makes what previously was clear seem doubtful, and before which even well settled principles of the law will bend.

Northern Securities Co. v. United States, 193 U.S. 197, 400-401 (1904) (Holmes, J., dissenting).

The Third Circuit responded to such "hydraulic pressure." Faced in the first instance with a new method for reviewing benefit determinations, the Court eschewed the "combination-of-factors method of review" and upheld the benefit determination based upon reasoning inapposite to the facts contained in the administrative record, the conclusion reached by MetLife and the reasoning MetLife reported to Feigenbaum for the basis of its opinion. Nothing in the *Glenn* opinion provides a lower court with the discretion to apply the newly adopted method of review based upon a summary conclusion that application of the review method would not make a difference. This is particularly true where, as here, the conclusion was based upon an irrelevant argument outside of the administrative record.

The Third Circuit's decision to avoid any meaningful application of the "combination-of-factors method of review" has further created a conflict among the circuit courts that have addressed the new standard

since *Glenn* was decided. The circuit courts confronted with the new method of review have either applied it themselves or remanded the case to the district court with instructions to apply the new analysis to the benefit determination. *McCauley v. First UNUM*, 551 F.3d 126 (2d Cir. 2008); *Chronister v. Unum Life*, 2009 U.S. App. LEXIS 9033 (8th Cir. 2009); *Burke v. Pitney Bowes Inc. Long-Term Disability Plan*, 544 F.3d 1016 (9th Cir. 2008); *Lee v. Bellsouth Telecommunications, Inc.*, 2009 U.S. App. LEXIS 5124 (11th Cir. 2009).

Review by this Court is also necessary to address the Third Circuit's decision to ignore the discovery issues raised by Feigenbaum on appeal. By not addressing these arguments, the Third Circuit has tacitly created a conflict with the First and Ninth Circuit Courts of Appeal concerning the proper scope and use of discovery in an ERISA case under the "combination-of-factors method of review." *Denmark v. Liberty Life Assr. Co. of Boston*, 2009 U.S. App. LEXIS 9825 (1st Cir. May 6, 2009); *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

I. REVIEW IS WARRANTED TO RESOLVE A CONFLICT CREATED BY THE THIRD CIRCUIT'S CONSIDERATION OF EVIDENCE OUTSIDE THE ADMINISTRATIVE RECORD

Prior to this Court's decision in *Firestone Tire & Rubber Company v. Bruch*, 489 U.S. 101 (1989), circuit courts were in agreement that in reviewing a fiduciary's decision under a deferential review, a trial court was limited to the evidence before the fiduciary at the time of the fiduciaries final decision. After *Firestone*, the circuit courts remain uniform on this

ERISA rule of law. *See* e.g., *Lopes v. Metropolitan Life Ins. Co.*, 332 F.3d 1 (1st Cir. 2003); *Gooden v. Provident Life & Acc. Ins. Co.*, 250 F.3d 329 (5th Cir. 2001); *Heaser v. Toro Co.*, 247 F.3d 826 (8th Cir. 2001); *Univ. Hosps. Of Cleveland v. Emerson Elec. Co.*, 202 F.3d 839 (6th Cir. 2000); *Martin v. Blue Cross & Blue Shield of Va.*, 115 F.3d 1201 (4th Cir. 1998); *Layes v. Mead Corp.*, 132 F.3d 1246 (8th Cir. 1998); *Thibodeaux v. Continental Cas. Ins. Co.*, 138 F.3d 593 (5th Cir. 1998); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433 (3d Cir. 1997h); *Bernstein v. Capitalcare, Inc.*, 70 F.3d 783 (4th Cir. 1995; *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375 (7th Cir. 1994); *Southern Farm Bureau Life Ins. Co.*, 993 F.2d 98 (5th Cir. 1993); *Miller v. Metro Life Ins. Co.*, 925 F.2d 979 (6th Cir. 1991); *Oldenburger v. Central States, Southeast & Southwest Areas Teamster Pension Fund*, 934 F.2d 171 (8th Cir. 1991); *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995); *Sandoval v. Aetna Life & Gas Co.*, 967 F.2d 377 (10th Cir. 1992); *Jett v. Blue Cross & Blue Shield of Ala.*, 890 F.2d 1135 (11th Cir. 1989).

The district court held that a deferential standard of review applied to MetLife's benefit determination. This holding was proper, even under the decision of this Court in *Glenn*. *Glenn*, 128 S. Ct. at 2350. It then erroneously went outside the administrative record and the expressed reasons for MetLife' benefit determination, when it decided the benefit determination was appropriate. The court focused upon treatment records based upon an attorney argument that had no basis in the administrative record or MetLife's benefit determination. The Third Circuit affirmed this erroneous analysis without meaningful explanation.

ERISA does not permit a fiduciary to assert "after-the-fact" reasons to bolster a previously made benefit determination. *See, Reich v. Ladish Co., Inc.*, 306 F.3d 519, fn 1 (7th Cir. 2002)("*Ladish* was required to give *Reich* every reason for its denial of benefits at the time of the denial."); *Skretvedt v. E.I. Dupont de Nemours and Co.*, 2001WL 1185796 (3d. Cir. 2001) (citing, *University Hospitals of Cleveland v. Emerson Electric Co.*, 202 F.3d 839, 849 (6th Cir. 2000) (the testimony of a committee member is not permitted to "shore-up" a deficient denial letter by consulting with an attorney to develop "creative *post hoc* arguments . . ."); *Shelden v. Barre Belt Granite*, 25 F.3d 74 (2d Cir. 1994)(district court cannot affirm a denial of benefits by ascribing to the plan a reason for denial other than the one proffered to the claimant); *Matuszak v. Torrington Company*, 927 F.2d 320 (7th Cir. 1991) (*post-hoc* reasons for denial not entitled to deference by reviewing court).

The Third Circuit not only permitted MetLife to "shore-up" its benefit determination, it accepted and exclusively relied upon this *post-hoc* rational to decide Feigenbaum's appeal.

II. REVIEW IS WARRANTED BECAUSE THE THIRD CIRCUIT'S OPINION HAS SUBSTANTIALLY DEPARTED FROM THE ACCEPTED METHOD OF ADJUDICATING ERISA CLAIMS

The exercise of this Court's supervisory power is warranted because of the Third Circuit's clear reliance upon information outside the administrative record. The opinion not only conflicts with all other circuit courts, but even more disturbingly, creates a conflict

within the Third Circuit. Third Circuit precedent has long held that a district court may not consider evidence extraneous to the administrative record. *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir. 1997); *Abnathya*, 2 F.3d at 48 n.8.

The Third Circuit confirmed the reasoning behind this rule as follows:

> As an initial matter, the District Court properly limited the record on summary judgment to the administrative record that was before the Trustees at the time of their decision. Because the purpose of arbitrary and capricious review is to determine the reasonableness of the determination at the time it was made, the reviewing court may only consider evidence that was contained in the record at that time. *Mitchell*, 113 F.3d at 440; *Abnathya*, 2 F.3d at 48 n.8. The purpose of [*386] so limiting the record is to encourage communication between plan administrators or fiduciaries and beneficiaries in order that conflicts can be resolved without resort to litigation. *See Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 300 (5th Cir. 1999). To allow the introduction of evidence as to what occurred after the administrative process had been completed would effectively [**13] remove any incentive to conduct an adequate investigation of claims to resolve disputes at the administrative level – precisely what the Trustees failed to do here.

Carney v. Int'l Brotherhood of Elec. Workers Pension Fund, 66 Fed. Appx. 381, 385-86 (3d Cir. 2003).

This reasoning cannot be reconciled with the Third Circuit's opinion in this case. By affirming MetLife's benefit determination, the Third Circuit ignored these laudatory goals and rewarded MetLife for its non-fiduciary conduct, which included the concealment of a medical test identified by its own medical consultant that would have objectively determined whether Feigenbaum remained totally disabled.

III. REVIEW IS WARRANTED BECAUSE THE THIRD CIRCUIT DID NOT ANALYZE METLIFE'S CLAIM DENIAL UNDER THE COMBINATION-OF-FACTORS STANDARD ADOPTED BY THE SUPREME COURT IN *GLENN*

Although not specified in the Third Circuit's opinion, questioning at oral argument raised the issue of whether sufficient medical records existed to support Feigenbaum's disability at the time MetLife terminated disability benefits. This was a *post-hoc* argument, unsupported by the administrative record or MetLife's denial letters, and raised at summary judgment and on appeal to support a "shore-up" erroneous benefit determination. (See e.g. A958, 960) In order to reach this conclusion, MetLife would have had to determine during the administrative review process that Feigenbaum was not receiving appropriate medical care and treatment for her disabling condition and symptoms. No such finding was ever made.

Ultimately, we are left with a claim denial based upon the identical records MetLife reviewed and approved Feigenbaum's disability claim for three (3)

years. Nothing changed with respect to Feigenbaum's disability. Even before *Glenn*, Third Circuit authority recognized a reversal of a determination to approve disability benefits without additional information as indicative of a procedural irregularity warranting a heightened standard of review. *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000) (Courts "look not only at the result . . . but at the process by which the result was achieved. In doing so we note several problems. . . . Reliance standard reversed its own initial determination that *Pinto* was totally disabled without receiving any additional medical information.")

The same holds true for MetLife's claim denial since it is undisputed that it obtained no additional medical evidence before terminating Feigenbaum's benefits. The Third Circuit's decision, therefore, contradicts well established Third Circuit authority. See *Post*, *infra.*, 501 F.3d at 164-165.

In *Glenn*, the Court specifically held that financial conflict of interest must reduce the level of deference afforded to the conflicted administrator, and that further evidence of conflicts, i.e., procedural irregularities in the adjudicative process, would increase the skepticism of the reviewing court. *Glenn*, 128 S. Ct. at 2351-52. The *Glenn* Court emphasized that courts are fully capable of reviewing the record as a whole when evaluating the impact of a conflict of interest to reach a result that takes into account the conflict. Id. at 2351.

Glenn represents a departure from the total deference or slightly diminished deference afforded a

conflicted administrator. No longer is a court constrained to overturn a claim determination only where the plan administrator's decision was "without reason, unsupported by the evidence or erroneous as a matter of Law." *Martorona v. The Bd. of Trustees of Steamfitters Local, Union 420 Health, Welfare and Pension Funds*, 404 F.3d 797, 801 (3d Cir. 2005). In adopting the new standard of review, the *Glenn* Court confirmed that "deferential" judicial review in a denial of benefits case is to be probing, thorough, critical, and based upon the record as a whole. Id. Any approach that substitutes instead a myopic search for any evidence supporting a denial of benefits is improper.

The Third Circuit refused to apply the *Glenn* analysis concluding that the claim determination "was not so close that any alleged procedural errors unaddressed by the district court might tip the scales in favor of reversal or were otherwise harmless." Unfortunately, the district court did not address any procedural irregularities, including the fact that MetLife: (1) terminated benefits without additional medical evidence; (2) concealed information from Feigenbaum during its administrative review; (3) acted in its own self-interest at every crossroad of the administrative review process; and (4) based its decision on the opinion of a biased medical examiner. These are not insignificant factors and certainly could have altered the judicial result.

The Third Circuit decided not to apply the combination-of-factor review annunciated in *Glenn* because it believed such an analysis would not change the outcome. The Third Circuit cited *Wakkinen v. UNUM Life Ins. Co. of Am.*, 531 F.3d 575 in support of

its decision. However, *Wakkinen* is factually inapposite to Feigenbaum's claim. In *Wakkinen*, the Court held that there was no reason to apply the *Glenn* analysis because the Plaintiff had failed to provide sufficient proof that he remained disabled during the elimination period contained in the plan at issue. *Wakkinen*, 531 F. 3d at 582-583. Feigenbaum satisfied this hurdle and was paid disability benefits for three (3) years. Thus, the procedural irregularities left unaddressed in connection with MetLife's claim determination could very well be so "close" as to tip the scale in favor of reversal. At a minimum, the Third Circuit should have remanded the matter to the district court in order to address these procedural irregularities.

Feigenbaum did not even need the method of review adopted by the majority of the Court in *Glenn*. MetLife's benefit determination would have been properly reversed under Justice Scalia's proposed analysis of ERISA benefit determinations. *Glenn*, 128 S. Ct. 2359. Under the Restatement of Trusts, a fiduciary abuses its discretion in four (4) circumstances: (1) the fiduciary acts dishonestly; (2) the fiduciary acts with improper motive; (3) the fiduciary fails to use judgment; or (4) the fiduciary acts beyond the boundaries of reasonable judgment. Id.

A cursory review of the administrative record as summarized in the Statement of the Case reveals that MetLife's benefit determination was the natural by-product of these four (4) fiduciary failures.

IV. REVIEW IS WARRANTED BECAUSE THE THIRD CIRCUIT'S OPINION IGNORED DISCOVERY ISSUES RAISED ON APPEAL AND CREATED A CONFLICT WITH TWO CIRCUIT COURTS

The scope of review mandated when reviewing a claim decision under *Glenn* has further, and necessarily, impacted the amount of discovery permitted on the various "factors" a court must balance under the "combination-of-factors method of review." Many of the factors lie outside the administrative record and therefore discovery is necessary to properly unfetter courts applying the method of review. *Glenn* indicates that much evidence outside the record will be relevant to determining whether an insurer abused its discretion. *Glenn*, 128 S. Ct. at 2350.

This aspect of the *Glenn* decision comports with Third Circuit precedent. *Kosiba v. Merck & Co.*, 384 F.3d, 58, 67 n.5 (3d Cir. 2004); *Pinto v. Reliance Std Life Ins. Co.*, 214 F.3d, 377, 395 (3d Cir. 2000); *Friess v. Reliance Standard Insurance Co.*, 122 F. Supp. 2d 566 (E.D. Pa. 2000). The Third Circuit has held that "when a reviewing court is deciding whether to employ the arbitrary and capricious standard or a more heightened standard of review, it may consider evidence of potential biases and conflicts of interest that are not found in the administrator's record." *Johnson v. UMWA Health and Retirement Funds*, 125 Fed. Appx. 400, 405-06 (3d Cir. 2005);

By failing to address this issue, the Third Circuit created a conflict with both the First and Ninth Circuit Courts of Appeal. Both Circuit Courts have recognized that post-*Glenn*, limited discovery

was appropriate to apply the "combination-of-factors method of review." *See Denmark*, 2009 U.S. App. LEXIS at *3; *Nolan*, 551 F.3d at 1155. By not addressing the propriety of the district court's discovery ruling, the Third Circuit could not have properly applied the "combination-of-factors method of review" in a manner anticipated by this Court.

CONCLUSION

For all of the foregoing reasons, Petitioner respectfully requests that the Supreme Court grant review of this matter.

Respectfully submitted,

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(any footnotes trail end of each document)

NOTICE: NOT PRECEDENTIAL OPINION UNDER THIRD CIRCUIT INTERNAL OPERATING PROCEDURE RULE 5.7. SUCH OPINIONS ARE NOT REGARDED AS PRECEDENTS WHICH BIND THE COURT.

PLEASE REFER TO FEDERAL RULES OF APPELLATE PROCEDURE RULE 32.1 GOVERNING THE CITATION TO UNPUBLISHED OPINIONS.

No. 07-3573

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

LYNNE FEIGENBAUM,

Appellant

v.

MERRILL LYNCH & CO., INC. BASIC LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR; MERRILL LYNCH & CO., INC. SUPPLEMENTAL LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR; METROPOLITAN LIFE INSURANCE CO.; PLAN ADMINISTRATORS of the MERRILL LYNCH RETIREMENT PLAN, HEALTH INSURANCE PLAN, AND LIFE INSURANCE PLAN; MERRILL LYNCH & CO., INC; CORPORATIONS 1-30, fictitious defendants; Amended per Clerk's Order dated 10/1/07

January 15, 2009, Argued

February 2, 2009, Opinion Filed

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY. (D.C. Civil No. 06-cv-01075). District Judge: The Honorable Faith S. Hochberg.

COUNSEL: Kevin E. Barber, Esq. (Argued), Niedweske Barber, Morristown, NJ, Counsel for Appellant.

Randi F. Knepper, Esq. (Argued), McElroy, Deutsch, Mulvaney & Carpenter, Newark, NJ, Counsel for Appellees.

JUDGES: Before: SLOVITER, BARRY, and SILER, JR., * Circuit Judges.

OPINION

BARRY, *Circuit Judge*

Appellant Lynne Feigenbaum, a former employee of appellee Merrill Lynch & Co., Inc., participated in Merrill Lynch's ERISA-based Basic and Supplemental Long Term Disability Plans. At times relevant to this appeal, Merrill Lynch, as the plan administrator, delegated responsibility for claims administration to appellee Metropolitan Life Insurance Co. Feigenbaum applied for and received benefits under both plans in 2001. After an independent physician review in December 2003, MetLife terminated her benefits,

finding, among other things, that she had failed to submit documentation of an impairment that would prevent her from her work as a financial analyst. After Feigenbaum's appeal of this decision was denied, she filed suit under 29 U.S.C. § 1132(a)(1)(B). Following limited discovery and extensive argument on the cross-motions for summary judgment, by Opinion and Order dated August 2, 2007, the District Court granted defendants' motion.

We, too, have heard extensive argument and have considered the parties' written submissions, including those addressed to the fairly recent decision of the Supreme Court in *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), with its "combination-of-factors method of review." Suffice it to say that the evidence that Feigenbaum's reported vertigo has a physiological basis supporting the presence of a significant balance disorder preventing full-time work was sparse. Moreover, Feigenbaum failed to submit any additional medical documentation in support of her appeal from the termination of benefits. We conclude, therefore, that the decision to terminate those benefits was not so close that any alleged procedural errors unaddressed by the District Court might tip the scales in favor of reversal or were other than harmless. As the Eighth Circuit concluded in a similar case which hewed closely to *Glenn*, "there is not a sufficiently close balance for the conflict of interest to act as a tiebreaker in favor of finding that [MetLife] abused its discretion." *Wakkinen v. UNUM Life Ins. Co. of Am.*, 531 F.3d 575, 582 (8th Cir. 2008).

We will affirm the judgment of the District Court.

Footnote

*The Honorable Eugene E. Siler, Jr., Senior Circuit Judge, United States Court of Appeals for the Sixth Circuit, sitting by designation.

Civil Case No. 06-1075 (FSH)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

LYNNE FEIGENBAUM,
Plaintiff,

v.

MERRILL LYNCH & CO., INC. BASIC LONG TERM DISABILITY PLAN, et al., Defendants.

August 2, 2007, Decided
August 2, 2007, Filed

NOTICE: NOT FOR PUBLICATION

COUNSEL: For LYNNE FEIGENBAUM, Plaintiff: MATTHEW JUSTIN VANCE, LEAD ATTORNEY, NIEDWESKE BARBER, PC, MORRISTOWN, NJ.

For MERRILL LYNCH & CO., INC., BASIC LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR, MERRILL LYNCH & CO., INC., SUPPLEMENTAL LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR, METROPOLITAN LIFE INSURANCE CO., PLAN ADMINISTRATORS of the MERRILL LYNCH RETIREMENT PLAN, HEALTH INSURANCE PLAN, and LIFE INSURANCE PLAN, MERRILL LYNCH, Defendants: RANDI F. KNEPPER, LEAD ATTORNEY, MCELROY, DEUTSCH, MULVANEY & CARPENTER, LLC, MORRISTOWN, NJ.

OPINION

HOCHBERG, District Judge

This matter comes before this Court upon the parties' cross motions for summary judgment [1] and the Court's May 14, 2007 oral argument on these motions.

I. Factual Background [2]

Plaintiff Lynne Feigenbaum seeks benefits pursuant to the Merrill Lynch employee welfare benefit plan, which is governed by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001 et seq ("ERISA"). Feigenbaum alleges that she was totally disabled from her occupation as a financial analyst since July 26, 2000 as a result of her vertigo/dizziness. As an employee of Merrill Lynch since December 9, 1987, Feigenbaum was a participant in the Basic and Supplemental Long Term Disability ("LTD") plans. [3] Defendant MetLife is the claims administrator for both the Basic LTD Plan and the Supplemental LTD Plan. The Basic LTD Plan is self-funded by Defendant Merrill Lynch & Co., Inc. ("Merrill Lynch"), and the Supplemental LTD Plan is insured through a policy of insurance issued by Defendant MetLife. Plaintiff's last day of work was July 26, 2000, and her Long Term Disability Employee Personal Profile states that her job required computer usage and walking for two hours a day, standing for two hours a day, and sitting for three to four hours a day.

Defendants paid Basic and Supplemental benefits from January 27, 2001 through January 21, 2004. Plaintiff had provided Defendants permission on January 3, 2001 to

receive and review Plaintiff's medical records, and on December 9, 2003, a nurse consultant recommended that an independent physician consultant review [*4] be performed. Accordingly, Defendant MetLife referred Plaintiff's records on December 24, 2003 to an independent physician consultant, Dr. Amy Hopkins, for a review. [4] Dr. Hopkins issued a report on December 24, 2003 which concluded that Plaintiff's vertigo was "largely self-reporting" and that her testing was "largely unremarkable." [5] Dr. Hopkins' report was sent to Plaintiff's treating physician, Dr. Frank Alario, on December 30, 2003 with a cover letter from MetLife that stated: "On December 10, 2003, we referred your patient's medical record to our Board-Certified Independent Physician Consultant for a file review. We are forwarding her report to you for your comments. There is no physical impairment that was objectively documented which would preclude the above claimant from returning to work, fulltime in her own job with no restrictions and limitations. If you do not agree with this conclusion, please fax your reply and any new medical documentation by January 30, 2004. If we do not hear from you by this time, we will assume that you agree with this decision." Defendant MetLife received no response from Dr. Alario, and Defendant MetLife denied Plaintiff's claim for continuing [*5] benefits on January 21, 2004. [6] Defendant MetLife's January 21, 2004 denial noted that Plaintiff's vertigo "has been largely self-reported" and that "[t]here is no objective evidence that your vertigo has a physiological basis and is actually impairing you." The letter also states that "The actual objective findings on exam do not support the presence of a significant balance disorder which would prevent you from performing sedentary work activities, such as your own occupation, on a full-time

basis, without restrictions or limitations." The denial letter concluded that "[n]o documentation was submitted to indicate any impairments that would prevent you from performing your occupation" and that "[y]ou no longer meet the definition of disability."

Plaintiff appealed the denial of benefits by letter dated February 24, 2004. Plaintiff's letter states that "[f]ollowing my two vestibular nerve sections, I still experience dizziness, vision distortions and headaches brought on by minimal computer usage and reading. These problems have kept me from driving and returning to work."[7] Plaintiff's letter noted that she "will be undergoing an MRI and extensive vision exam to ascertain if anything additional is causing the existing problem." Plaintiff attached her physical therapy records from July 2003, which had been faxed to Merrill Lynch Disability on September 15, 2003 and were included in the record when the claims administrator denied Plaintiff's LTD benefits on January 21, 2004. Plaintiff also attached a February 23, 2004 letter from Dr. Alario, Plaintiff's treating physician, which stated that he supported her right to long-term disability benefits.[8] Plaintiff did not submit any other documentation to Defendant MetLife.

Defendant MetLife denied Plaintiff's appeal by letter dated April 19, 2004. The denial letter noted that a Board certified independent physician consultant [Dr. John Rogers] had reviewed the documentation, including Plaintiff's submissions with her appeal, and that "the documentation does not support an inability to perform the duties of your sedentary job as of January 22, 2004 onward." [9]

II. Analysis

A. Summary Judgment Standard

Pursuant to Fed. R. Civ. P. 56(c), a motion for summary judgment will be granted if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986). In other words, "summary judgment may be granted only if there exists no genuine issue of material fact that would permit a reasonable jury to find for the nonmoving party." *Miller v. Indiana Hosp.*, 843 F.2d 139, 143 (3d Cir. 1988). A fact is material if it might affect the outcome of the case, and an issue is genuine if the evidence is such that a reasonable fact finder could return a verdict in favor of the nonmovant. *Anderson*, 477 U.S. at 248 (1986); *In re Headquarters Dodge*, 13 F.3d 674, 679 (3d Cir. 1993).

All facts and inferences must be construed in the light most favorable to the non-moving party. *Peters v. Delaware River Port Auth.*, 16 F.3d 1346, 1349 (3d Cir. 1994). The party seeking summary judgment always bears the initial burden of production. *Celotex Corp.*, 477 U.S. at 323. This requires the moving party to establish either that there is no genuine issue of material fact and that the moving party must prevail as a matter of law, or to demonstrate that the non-moving party has not shown the requisite facts relating to an essential element of an issue for which it bears the

burden. *Id.* at 322-23. Once the party seeking summary judgment has carried this initial burden, the burden shifts to the non-moving party. To avoid summary judgment, the non-moving party must demonstrate facts supporting each element for which it bears the burden, and it must establish the existence of "genuine issue[s] of material fact" justifying trial. *Miller*, 843 F.2d at 143; see also *Celotex Corp.*, 477 U.S. at 324.

If a moving party satisfies its initial burden of establishing a prima facie case for summary judgment, the opposing party "must do more than simply show that there is some metaphysical doubt as to material facts." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986). "Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no 'genuine issue for trial.'" *Id.* at 587 (quoting *First Nat'l Bank of Arizona v. Cities Serv. Co.*, 391 U.S. 253, 289, 88 S. Ct. 1575, 20 L. Ed. 2d 569 (1968)). The Court also uses this standard when cross-motions have been filed. *Weissman v. U.S. Postal Serv.*, 19 F.Supp. 2d 254, 259 (D.N.J. 1998) (citing *Southeastern Transp. Auth. v. Pennsylvania Pub. Utility Comm'n*, 826 F.Supp. 1506, 1512 (E.D.Pa.1993), aff'd, 27 F.3d 558 (3d Cir.1994)).

B. Standard of Review

Where an ERISA-governed benefit plan gives the plan administrator or fiduciary discretion in "interpret[ing] the plan and making benefits determinations," as Defendants have in this case, a court reviewing a benefits denial employs an "arbitrary and capricious" standard. *Skretvedt v. E.I. Dupont De Nemours & Co.*,

268 F.3d 167, 173-74 (3d Cir. 2001). Under this standard, the reviewing court must defer to the administrator unless its decision was "'without reason, unsupported by substantial evidence, or erroneous as a matter of law.'" *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000) (noting that a plan administrator's decision is supported by substantial evidence if the evidence is sufficient for a reasonable person to agree). The arbitrary and capricious standard is then heightened where the structure of a plan presents an inherent conflict of interest or where specific facts in evidence call the impartiality of the administrator into question. *Pinto*, 214 F.3d at 383-84; *Goldstein v. Johnson & Johnson*, 251 F.3d 433, 442 (3d Cir. 2001); *Kosiba v. Merck & Co.*, 384 F.3d 58, 65-66 (3d Cir. 2004).

For instance, the Third Circuit has found that the potential for a conflict of interest exists where an employer both funds and administers a plan. *Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc.*, 298 F.3d 191, 197 (3d Cir. 2002). In Pinto, the Third Circuit established a "sliding scale approach" to use in such cases, intensifying the degree of scrutiny to match the degree of the conflict. [10] 214 F.3d at 391. However, even if the court applies a heightened arbitrary and capricious standard of review, the Third Circuit has held that "a court may not substitute its own judgment for that of the plan administrators." *Stratton v. E.I. DuPont De Nemours & Co.*, 363 F.3d 250, 256 (3d Cir. 2004) (citing *Smathers*, 298 F.3d at 199). Regardless of which standard a court applies, it "must base its ultimate determination on the record before the plan administrator," *Kosiba*, 384 F.3d at 69. The Court may only overturn a plan administrator's decision "if it is clearly not supported by the evidence in the record or

the administrator has failed to comply with the procedures required by the plan." *Smathers*, 298 F.3d at 199.

In this case, Defendant MetLife is the claims administrator for both the Basic LTD Plan and the Supplemental LTD Plan. The Basic LTD Plan is self-funded by Defendant Merrill Lynch, and the Supplemental LTD Plan is insured through a policy of insurance issued by Defendant MetLife. Because the Basic LTD Plan is administered and funded by distinct entities, the Court will apply an arbitrary and capricious standard when considering the denial of Plaintiff's Basic LTD Plan. [11] See *Skretvedt*, 268 F.3d at 173-174. Since MetLife is both the claims administrator and responsible for paying benefits with respect to the Supplemental LTD Plan, the Court will apply a heightened arbitrary and capricious standard when considering the denial of Plaintiff's Supplemental LTD Plan. See *Pinto*, 214 F.3d at 387-388 and Smathers, 298 F.3d at 197.

C. Record before the Claims Administrator

Among other documents, the record before the claims administrator included the following information:

- Documents from 2000: Records from JFK Johnson Rehabilitation Institute for physical therapy occurring on ten days between November 2000 and January 2001 (129-147); various correspondence from doctors from February to August 2000 (120; 122-123; 124-125; 126-127; 148-152; 270-271; 305; 306-308); a January 3, 2001

Long Term Disability Employee Personal Profile (117-119);

- Documents from 2001: Dr. Alario's March 26, 2001 Attending Physician Statement (114-115); Progress notes from Atlantic Coast Ear Specialists, P.C., from February 5, 2001 to June 15, 2001 (157-161); Dr. Alario's medical records from November 1996 to March 2001 (179-230); Medical literature regarding vertigo (231-233); Office visit notes from Atlantic Coast Ear Specialists, P.C. from February 5, 2001 to June 15, 2001 (264-268); May 11, 2001 correspondence from Mark J. Kupersmith, M.D. to Paul Hammerschlag, M.D., regarding a neuro-ophthalmic evaluation (236-237); July 2, 2001 correspondence from Dr. Alario to HMO Blue requesting authorization for immediate antibiotic intravenous therapy (269); JFK Johnson Rehabilitation Institute notes of physical therapy occurring on July 16, 2001, July 26, 2001, and August 27, 2001 (238-242); Updated medical records from Dr. Alario (for August 22, 2001, July 2, 2001, and July 23, 2001) and corresponding lab results (244-259); September 5, 2001 request for medical records from Merrill Lynch to Dr. Alario (243); October 22, 2001 Physical therapy records from JFK Johnson Rehabilitation Institute (260-263);
- Documents from 2002: Physical therapy records from JFK Johnson Rehabilitation

Institute from March 14, 2002 to April 4, 2002 (272-288);

- Documents from 2003: June 12, 2003 Office note of Phillip Kramer, M.D. summarizing examination and attaching a blank Physical Capacities Evaluation stating, "I am not qualified to make this evaluation" (084-086); July 30, 2003 JFK Johnson Rehabilitation Institute Physical Therapy Vestibular Evaluation (289-291); September 5, 2003 request for Plaintiff's physical therapy records from Merrill Lynch (338);
- Documents Relating to MetLife's 2004 Termination of Plaintiff's LTD benefits: December 24, 2003 Physician Consultant Review report from Independent Physician Consultant Dr. Hopkins (075-078); fax of report to Dr. Frank Alario (Plaintiff's treating physician) (068-074); Defendant MetLife's January 21, 2004 termination letter (065-067); Plaintiff's February 24, 2004 appeal (337); Independent Physician Consultant Dr. Rodgers' April 14, 2004 report (61-62); and Defendant MetLife's April 19, 2004 denial of Plaintiff's appeal.

D. Administrator's Decision to Deny Benefits

Plaintiff argues that Defendant MetLife wrongfully terminated her Basic and Supplemental LTD benefits. The Court "must base its ultimate determination on the record before the plan administrator," *Kosiba*, 384 F.3d at 69, and the Court may only overturn a plan

administrator's decision "if it is clearly not supported by the evidence in the record or the administrator has failed to comply with the procedures required by the plan." *Smathers*, 298 F.3d at 199. As discussed above, the Court will review Defendants' denial of Plaintiff's Basic LTD benefits under an arbitrary and capricious standard and its denial of Plaintiff's Supplemental LTD benefits under a heightened arbitrary and capricious standard.

After carefully considering the documents in the administrative record and applying the above standard of review, the Court holds that Defendants' denial of Plaintiff's Basic LTD and Supplemental benefits was not arbitrary and capricious. MetLife's denial of Plaintiff's LTD benefits was not "'without reason, unsupported by substantial evidence, or erroneous as a matter of law.'" *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000). In its January 21, 2004 denial letter, Defendants noted the lack of objective evidence of Plaintiff's condition in her file and highlighted the December 24, 2003 report of Dr. Amy Hopkins, an independent physician consultant, which noted that Plaintiff's vertigo was "largely self-reporting;" that her testing was "largely unremarkable;" and that "[o]f note are the numerous mentions of evidence of non-organic behavior in this record, consistent w/ somatization or malingering." Although Defendant MetLife highlighted that it did not have objective evidence of Plaintiff's condition, Plaintiff's February 24, 2004 appeal did not provide any objective medical evidence.

Plaintiff's appeal included a letter from Plaintiff describing her symptoms; old physical therapy records

from July 2003 which had been faxed to Merrill Lynch Disability on September 15, 2003 and had already been considered when the claims administrator denied Plaintiff's LTD benefits on January 21, 2004; and a February 23, 2004 ten-line letter from Dr. Alario, Plaintiff's treating physician, which summarized Plaintiff's symptoms and stated that objective testing would be done, but not stating the conclusions of any objective testing that had actually been done. Although Dr. Alario suggested that Plaintiff would be undergoing additional tests, Plaintiff did not submit any further test results, did not request additional time in order to submit any results, and did not provide any submission to Defendant MetLife indicating when Plaintiff would be able to provide such additional documentation.

MetLife's April 19, 2004 denial letter of Plaintiff's appeal noted that a Board certified independent physician consultant, Dr. John Rogers, had reviewed the documentation, including Plaintiff's submissions, and had concluded that "[b]ased on the lack of any further objective data, there is still no documentation which would clearly substantiate an organic cause for your dizziness and abnormal eye motion." [12] The letter stated that "the documentation does not support an inability to perform the duties of your sedentary job as of January 22, 2004 onward."

III. CONCLUSION

Defendants' motion for summary judgment is granted and Plaintiff's motion for summary judgment is denied. [13] An appropriate order will issue.

/s/ Faith S. Hochberg

Hon. Faith S. Hochberg, U.S.D.J.

Footnotes

1 In a May 8, 2007 letter to this Court, Plaintiff withdrew Count Three of Plaintiff's Complaint with prejudice.

2 This factual background summary is taken from uncontested facts in Plaintiff's and Defendants' L. Civ. R. 56.1 Statements of Material Facts.

3 The Basic LTD Plan states that "Basic LTD payments begin after you are totally disabled for six months and the claim administrator approves your application for benefits. The six-month waiting period begins on the first day you are not at work because of your total disability. You are considered totally disabled if you are unable to perform all of the regular duties of the Merrill Lynch job you had before your disability began and are under the continuance care of a doctor." The Supplemental LTD Plan states that "Supplemental LTD plan benefits generally begin when your basic LTD plan benefits do. You must be totally disabled as determined by the supplemental LTD plan insurance company. To be considered totally disabled, you must be unable to perform all of the regular duties of the Merrill Lynch job you had before your disability began and be under the continuous care of a doctor. See the Glossary for the definition of doctor. Your eligibility to receive a benefit is subject to approval by the insurance company for the supplemental LTD plan. It may be possible to qualify for basic LTD plan benefits and not qualify for supplemental LTD plan benefits."

4 Dr. Hopkins has a M.D., M.P.H., and Ph.D.; is board certified in Internal Medicine and Occupational Medicine; and is a Fellow of the American College of Occupational and Environmental Medicine.5 Dr. Hopkins' report states that: "In terms of EE [en.ployee]'s vertigo, it has been largely self-reported, though there have been some nonspecific findings over the course of the last several years. EE [employee] has had some improvement with two vestibular nerve sections, but still reports intermittent vertigo. EE [employee] has had many course of vestibular therapy without clear improvement. Testing has been largely unremarkable. Of note are the numerous mentions of evidence of non-organic behavior in this record, consistent w/ somatization or malingering. Dr. Katz documented bizarre eye movements an astasia/abasia gait, and falling backwards on Romberg testing. Ms. McCall documented marked differences between observed and unobserved testing, and sx [symptoms] exaggeration. Dr. Kupersmith documented falling backwards on Romberg testing. Dr. Kramer documented changes on infrared video oculography which could be voluntary. He also noted that EE [employee] wanted to get pregnant, which would be surprising on EE's [employee's] part if she was truly as disabled as she claimed to be. It is not clear why EE [employee] apparently feels she can take care of an infant, in the absence of any indication that she would be turning care over to someone else, but not work. These observations give strong support to the presence of a non-organic behavior contributing to it even causing EE's sx [employee's symptoms]. It is surprising that computerized dynamics posturography was not documented as having been performed, since it is the gold standard for determining if someone's vertigo has

a physiological basis and is actually impairing him or her. Without this test, EE's [employee's] vertigo remains largely as self-reported sx [symptoms] w/ no definite evidence of objective imbalance when taking into account the inconsistent findings on exams. The actual objective findings on exam do not support the presence of a significant balance disorder which would prevent EE [employee] from performing sedentary work activities, such as her own occupation, on a full-time basis, without restrictions and limitations."6 The January 21, 2004 letter from Defendant MetLife to Plaintiff informed Plaintiff how to appeal the decision:

"You may appeal this decision by sending a written request for appeal to MetLife Disability...within 180 days after you receive this denial letter. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records, or other information relating to your claim that you deem appropriate for us to give your appeal proper consideration. Upon request, MetLife will provide you with a copy of the documents, records, or other information we have that are relevant to your claim and identify any medical or vocational expert(s) whose advice was obtained in connection with your claim...For us to reconsider your claim you need to provide us with medical evidence from the doctor(s) treating you for a condition that indicates you are under the appropriate care and treatment and objective medical information to support your inability to perform the duties of your occupation. Office notes from your treating doctors and information regarding your functional impairments and work restrictions must be provided."

The January 21, 2004 letter also noted that "MetLife will evaluate all the information and advise you of our determination of your appeal within 45 days after we receive your written request for appeal. If there are special circumstances requiring additional time to complete our review, we may take up to an additional 45 days, but only after notifying you of the special circumstances in writing."

7 Plaintiff's letter also states that "Per Dr. Kramers' suggestion I went back to vestibular therapy from July 2003 to August 2003 (records attached) to address the above problems and try to correct them. These sessions were unsuccessful because every time I tried to do the requested vestibular exercise I would wind up dizzy and lightheaded and spend the next twenty-four hours on the couch unable to function."

8 Dr. Alario's letter stated: "[Feigenbaum] is unable to return to work due to chronic vertigo and unstable eye movements. Ms. Feigenbaum is unable to drive due to the above-mentioned symptoms. The vertigo and the presence of a delayed eye focus when her head or eyes move from side to side or up and down, prevents her from reading and working on the computer for more than an estimated one hour period at a time. These complaints also cause her comprehension and retention problems. The patient recently started Strattera 4 mg. at bedtime for attention deficit complaints. The above tasks are a main function of her employment, and at this time she is unable to perform these tasks. The patient is also suffering from intermittent headaches and numbness/tingling in her extremities. Ms. Feigenbaum is undergoing further testing to ascertain any possible causes of the above symptoms, including an MRI, eye

exam, and will be seeing a neuro-opthomologist. Due to the lack of improvement with various medical treatments rendered, it is my recommendation that she must remain on disability. Please feel free to contact me if you have questions in this matter."

9 The April 19, 2004 denial states that "The physician [consultant, Dr. John Rogers] noted that at no time have you exhibited well-documented observed organic symptoms...The physician concluded that a [February 23, 2004] letter from Dr. Alario [Plaintiff's treating physician] furnished for appeal consideration does not contain objective evidence of continued functional impairments that would preclude your ability to perform at a sedentary level of exertion consistent with your own occupation. Dr. Alario stated your (sic) are symptomatic and would be undergoing further testing including an MRI and an eye examination. Based on the lack of any further objective data, there is still no documentation which would clearly substantiate an organic cause for your dizziness and abnormal eye motion."

10 The factors to consider when determining the degree of the conflict include (1) the sophistication of the parties; (2) the information accessible to the parties; (3) the exact financial arrangement between the insurer and the company; and (4) the current status of the fiduciary (i.e. whether the decisionmaker is a current employer, former employer, or insurer). See *Kosiba*, 384 F.3d at 64.

11 Plaintiff argues that the Court should use a heightened standard of review because Defendant MetLife (1) utilized the services of physician

consultants who have no experience or training in vertigo and balance disorders; (2) incorrectly required objective evidence of disability; (3) improperly failed to have the consulting physicians perform a person-to-person examination of Plaintiff; (4) improperly failed to advise Plaintiff of the need to secure posturography test results; (5) did not secure any surreptitious surveillance that Plaintiff is a malinger; and (6) failed to acquire a proper vocational assessment. These arguments are without merit as applied in this case. It is not arbitrary and capricious for a claims administrator to require objective evidence showing the physical limitations imposed by Plaintiff's vertigo. See *Boardman v. Prudential Ins. Co. of America*, 337 F.3d 9, 17 (1st Cir. 2003). Further, there is no ERISA requirement that an in-person evaluation or surreptitious surveillance be performed.

12 Defendants' January 21, 2004 initial denial letter to Plaintiff stated that "MetLife will evaluate all the information and advise you of our determination of your appeal within 45 days after we receive your written request for appeal. If there are special circumstances requiring additional time to complete our review, we may take up to an additional 45 days, but only after notifying you of the special circumstances in writing." Plaintiff submitted her appeal on February 24, 2004, and Defendants denied the appeal on April 19, 2004, more than 45 days later.

13 This case is distinguishable from *Shah v. Broadspire Servs.*, Civil Action No. 06-3106, 2007 U.S. Dist. LEXIS 56356, for which this Court granted Plaintiff Shah's summary judgment motion today. There, the Claims Review Committee based its denial of Plaintiff Shah's

disability benefits on an Employability Assessment which failed to consider Plaintiff's physiological limitations, as found by Plaintiff's doctor as well as Defendants' own exercise physiologist, in determining which sedentary jobs Plaintiff could actually do.

Filed 3/3/09

No. 07-3573

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

LYNNE FEIGENBAUM,

Appellant

v.

MERRILL LYNCH & CO., INC. BASIC LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR; MERRILL LYNCH & CO., INC. SUPPLEMENTAL LONG TERM DISABILITY PLAN and its PLAN ADMINISTRATOR; METROPOLITAN LIFE INSURANCE CO.; PLAN ADMINISTRATORS of the MERRILL LYNCH RETIREMENT PLAN, HEALTH INSURANCE PLAN, AND LIFE INSURANCE PLAN; MERRILL LYNCH & CO., INC; CORPORATIONS 1-30, fictitious defendants; Amended per Clerk's Order dated 10/1/07

January 15, 2009, Argued

February 2, 2009, Opinion Filed

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY.
(D.C. Civil No. 06-cv-01075). District Judge: The Honorable Faith S. Hochberg.

Present: SCIRICA, Chief Judge, SLOVITER, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, FISHER, and CHAGARES, and SILER, Circuit Judges*

SUR PETITION FOR REHEARING
WITH SUGGESTION FOR REHEARING EN BANC

The petition for rehearing en banc filed by Appellant having been submitted to the judges who participated in the decision of this Court, and to all the other available circuit judges in active service, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court en banc, the petition for rehearing en banc is DENIED.

Footnote

*The Honorable Eugene E. Siler, Jr., Senior Circuit Judge, United States Court of Appeals for the Sixth Circuit, sitting by designation.